U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
BAKER ORLAN DARRYL	#19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Busz intake	8-12-4	FCI ELKTON

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever
			Rheumatic fever
✓			Swollen or painful joints
✓			Frequent or severe headache
✓			Dizziness or fainting spells
			Eye trouble
			Ear, nose, or throat trouble
			Hearing loss
			Chronic or frequent colds
✓			Severe tooth or gum trouble
			Sinusitis
			Hay Fever
			Head injury
			Skin diseases
			Thyroid trouble
✓			Tuberculosis
✓			Asthma
✓			Shortness of breath
			Pain or pressure in chest
✓			Chronic cough
			Palpitation or pounding heart
			Heart trouble
			High or low blood pressure
			Cramps in your legs
			Frequent indigestion
			Stomach, liver, or intestinal trouble
			Gall bladder trouble or gallstones
			Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
			Adverse reaction to serum drug or medicine
			Broken bones
			Tumor, growth, cyst, cancer
			Rupture/hernia
			Piles or rectal disease
			Frequent or painful urination
			Bed wetting since age 12
			Kidney stone or blood in urine
			Sugar or albumin in urine
			VD—Syphilis, gonorrhea, etc.
✓			Recent gain or loss of weight
			Arthritis, Rheumatism, or Bursitis
			Bone, joint or other deformity
			Lameness
			Loss of finger or toe
			Painful or "Trick" shoulder or elbow
			Recurrent back pain
			"Trick" or locked knee
			Foot trouble
			Neuritis
			Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
			Epilepsy or fits
			Car, train, sea or air sickness
			Frequent trouble sleeping
			Depression or excessive worry
			Loss of memory or amnesia
			Nervous trouble of any sort
			Periods of unconsciousness
			Have you ever had homosexual contact?
			Been exposed to AIDS
			Alcohol Use (Excessive)
			Drug Use/Addiction
			Marijuana
			Cocaine
			Heroin
			L.S.D.
			Amphetamines
			Others: (Specify)
			Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

GENERAL MOTORS

12. ARE YOU (Check one)

☒ Right handed ☐ Left handed

000111

BP-360(60)

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*			20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE Darryl BAKER

SIGNATURE Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ✓ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ✓ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

D Lice
D Sunick

000112

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Gary Bullock Physician Assistant	8-12-4	G Bullock PA	

REVERSE

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY
AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
BAKER DARYL ORRIN	19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake	21 May	Lpe Bne

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

Good

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
✓			Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
✓			Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
✓			Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
✓	✓		Asthma		✓		Painful or "Trick" shoulder or elbow		✓		Amphetamines
✓	✓		Shortness of breath		✓		Recurrent back pain		✓		Others: (Specify)
✓	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
✓			Chronic cough		✓		Foot trouble		✓		Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis				Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion								Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

GENERAL MOTORS COPERATION

12. ARE YOU (Check one) ✓

☑ Right handed ☐ Left handed

000113

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.	✓		19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13–22 ABOVE)

O

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Darryl Baker

SIGNATURE: Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? no

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

DRUG ALLERGIES NKDA

MEDICATIONS 0

MEDICAL PROBLEMS ② orbital Fx plus referred to ophthalmology.

INFEC. DISEASE 0

LICE 0

SUICIDAL IDEATIONS 0

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Y. [illegible], M.D. NDC BROOKLYN	7/7/04	[illegible]	

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
[illegible] CARL [illegible] DAVIS	19613-039
3. PURPOSE OF EXAMINATION	**4. DATE OF EXAMINATION**
Intake Screening	10/18/95
5. EXAMINING FACILITY	FCI McKean

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

33 y.o. ♂ EHM — no med.

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever
	✓		Rheumatic fever
	✓		Swollen or painful joints
	✓		Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
	✓		Ear, nose, or throat trouble
	✓		Hearing loss
	✓		Chronic or frequent colds
	✓		Severe tooth or gum trouble
	✓		Sinusitis
	✓		Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
	✓		Shortness of breath
	✓		Pain or pressure in chest
	✓		Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure
	✓		Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach, liver, or intestinal trouble
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	✓		Jaundice or hepatitis
	✓		Adverse reaction to serum drug or medicine
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture/hernia
	✓		Piles or rectal disease
	✓		Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
	✓		Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
	✓		Recent gain or loss of weight
	✓		Arthritis, Rheumatism, or Bursitis
	✓		Bone, joint or other deformity
	✓		Lameness
	✓		Loss of finger or toe
	✓		Painful or "Trick"shoulder or elbow
	✓		Recurrent back pain
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
	✓		Frequent trouble sleeping
	✓		Depression or excessive worry
	✓		Loss of memory or amnesia
	✓		Nervous trouble of any sort
	✓		Periods of unconsciousness
	✓		Have you ever had homosexual contact?
	✓		Been exposed to AIDS
	✓		Alcohol Use (Excessive)
	✓		Drug Use/Addiction
	✓		Marijuana } Hx
	✓		Cocaine } Hx
	✓		Heroin
	✓		L.S.D.
	✓		Amphetamines
			Others: (Specify)
	✓		Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

Assembly Man

12. ARE YOU (Check one)

☑ Right handed ☐ Left handed

LVN

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason for rejections.)*
		D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

Medications	✓ No	___ Yes
Allergies	✓ No	___ Yes
Medical Complaints	✓ No	___ Yes
Evidence of Lice	✓ No	___ Yes
Hx of IV Drug Use	✓ No	___ Yes
Suicidal Throughts	✓ No	___ Yes

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: DARRYL ORRIN BAKER

SIGNATURE: Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ✓ P.V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

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DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? N/A

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___

GENERAL POPULATION ✓ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

POLYSUBSTANCE ABUSE

EDM –

COLONIC LBP

7/7/00 Reviewed : BrickDA C

DO YOU HAVE			
Frequent Colds	✓ No	___ Yes	
Thrush	✓ No	___ Yes	
Night Sweats	✓ No	___ Yes	
Diarrhea	✓ No	___ Yes	
Skin Rashes	✓ No	___ Yes	

Mark Peoria, PA-C

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER: D. K. PEL, FMG PA

DATE: 30 JUN 2000 / 10/18/95

SIGNATURE

USP LEWISBURG
HEALTH SERVICES UNIT
LEWISBURG, PA 17837

NUMBER OF ATTACHED SHEETS

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

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1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Bhat O. Derk	19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake Screening	10-4-95	FDC - Dr Lam

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

Good health

No meds

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had homosexual contact?
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight	✓			Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis	✓			Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity	✓			Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain				Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble		✓		Alcohol or drug Withdrawal Problems
	✓		Palpitation or pounding heart		✓		Neuritis				
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs								
	✓		Frequent indigestion								
	✓		Stomach, liver, or intestinal trouble								
	✓		Gall bladder trouble or gallstones								
	✓		Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
D.B.	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

Treatment Program 4 of the

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE Daniel O. [illegible]

SIGNATURE Daniel [illegible]

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NC

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? PE scheduled

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ✓

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION none

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

33 y/o, BM, NKA, Non smoker
Hx of Drug abuse

000118

TYPED OR PRINTED NAME OF EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
MARIO BAYONETO, PA	10-4-95	[illegible] PA	

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
OAKAR DARRIL ORRIN	19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Physical R&D attachment	6/8/95	F.D.C. MIAMI

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

(1) NO MEDS
(2) HEALTHY

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
	✓	Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓	✓	Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis			✓	Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity			✓	Cocaine
	✓		Thyroid trouble		✓		Lameness				Heroin
	✓		Tuberculosis		✓		Loss of finger or toe				L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow				Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain				Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble				Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis				Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion								Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?
GM Truck + Bus

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

000119

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
✓		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
✓		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

Treatment Center Insight
Treatment Center Turning Point

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Darryl Baker

SIGNATURE: Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN made? P.E. scheduled

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ✓

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____ needs P.E

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

32 BM
NKA
Polysubstance abuse

000120

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
STEPHEN GIDEL, PA PHYSICIAN ASSISTANT	6/8/95	Steph Gidel P.A	

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
[illegible]	08/26/05	1230

Inmate's Name	Register Number
Baker, Darryl	19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)
136/86

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: advised to follow up 8/29/05 S/C to discuss Eye

Medical Staff Signature	Date	Time
S. Gosa PA-C	08/26/05	1320

Medical Staff Title Samuel Gosa, PA-C
USP [illegible]burg

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000121

BP-S354.060 **INTAKE SCREENI (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
	8-12-04	1800

Inmate's Name	Register Number
Baker, Darryl	19615-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
G Bullock PA	8-12-04	1800

Medical Staff Title Gary Bullock
Physician Assistant

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000122

P-E354.060
DV 94

INTAKE SCREENING (MEDICAL)

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

MEDICAL STAFF SHALL COMPLETE THIS SCREENING FORM ON ALL ARRIVALS TO THE INSTITUTION

Institution	Date of Arrival	Time of Arrival
MPC Boo		

Name of Inmate	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARANCE

BP-149 (60) reviewed? ■ Yes ☐ No	Explain: O
General Population Housing Approved? ■ Yes ☐ No	Specify limitation or need
Approved for Temporary Work Assignment? ■ Yes ☐ No	Specify limitation or exclusion
For Holdovers: OK for Continued Transportation? ■ Yes ☐ No	Explain
Disabilities? ☐ Yes ■ No	If yes, enter code(s) into MDS)

Remarks

Medical Staff Signature	Medical Staff Title	
Y. MEDINILLA, PA-C MDC BROOKLYN	PA-C	
	Date: 7/7/04	Time: 2040

Record Copy - Inmate Central File; Copy - File

000123

Replaces BP-354(60) of APRIL 90 and BP-S354 of AUG 94

BP-S334.060 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP LEWISBURG Health Services Unit Lewisburg, PA 17837	7-1-04	1400

Inmate's Name	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARENCE

1. BP-149(60) reviewed? X yes; ☐ no (Explain)

2. General Population Housing Approved? X yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? X yes; ☐ no Specify limitations or exclusions.

No Food Service work until Medically cleared.

4. For Holdovers: OK for Continued Transport? X yes; ☐ no (Explain)

5. Disabilities? ☐ yes X no (If yes, enter code s into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
	7-1-04	1448

Medical Staff Title

D. McClintock; Paramedic *L. Potter; Paramedic*

B. Prince; Paramedic *R. Parkyn; Paramedic*

000124

Record Copy - Inmate Central File; Copy - file
(This form may be replicated via WP) (Replaces BP-S334.060 of APR 1994 and BP-S334 of AUG 1994)

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
McKean	9/12/02	

Inmate's Name	Register Number
Baker, Darryl	19613-029

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions) Pending

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:
Eth M
HOH/Or

Medical Staff Signature	Date	Time
Patricia Faulkner PAC	9/12/02	1220

Medical Staff Title
PA

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Lewisburg PA	6/30/02	1205

Inmate's Name	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☑ no (Specify limitation or need)
H/O

3. Approved for Temporary Work Assignment? ☑ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☑ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:
none

Medical Staff Signature	Date	Time
[signature]	6/30/02	1228

Medical Staff Title
Ivan Navarro, PA

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCI Loretto	7/7/00	

Inmate's Name	Register Number
Baker, Darryl	19613-034

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions)

Pending Clearance

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

NO LICS SUICIDAL IDEATION

Medical Staff Signature	Date	Time
Beth PA C	7/7/00	1225

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000127

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP LEWISBURG HEALTH SERVICES UNIT LEWISBURG, PA 17837	30 JUN 2000	1930

Inmate's Name	Register Number
BAKER, DANIEL	~~Lytt~~ 19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

o

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: NONE

NO Lic

Medical Staff Signature	Date	Time
[signature]	30 JUN 2000 7/7/00	1613 1222

Medical Staff Title
Mark Peoria, PA-C

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000128

BP-S354.060 **INTAKE SCREENI..** (MEDICAL) CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
McKean	10/18/95	

Inmate's Name	Register Number
Baker, Darryl	19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:
Elim.

Medical Staff Signature	Date	Time
	10/18/95	1730

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INTAKE SCREE. .NG *(MEDICAL)*

(Medical staff shall complete this screening form on all arrivals to the institution)

INSTITUTION	DATE OF ARRIVAL	TIME OF ARRIVAL
FDC - Mi. Ca.	10-4-95	1200

INMATE'S NAME	REGISTER NUMBER
Baker, Darryl	19613-039

MEDICAL CLEARANCE

[1] BP–149(60) REVIEWED? ☐ YES ☑ ~~NO~~ *(Explain):*

not available

[2] General Population Housing Approved? ☑ ~~YES~~ ☐ NO *(Specify limitation or need):*

[3] Approved for Temporary Work Assignment? ☐ YES ☑ ~~NO~~ *(Specify limitations or exclusions):*

[illegible] PS

[4] For Holdovers: OK for Continued Transport? ☑ ~~YES~~ ☐ NO *(Explain):*

[5] Remarks:

[illegible]

MEDICAL STAFF SIGNATURE	DATE
MARIO BAYONETO, PA	10-4-95
MEDICAL STAFF TITLE	**TIME**
PA	1325

ORIGINAL – INMATE CENTRAL FILE
CANARY – FILE

000130

USP LVN

BP–354(60)
APRIL 1990

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INTAKE SCREE NG *(MEDICAL)*

(Medical staff shall complete this screening form on all arrivals to the institution)

INSTITUTION	DATE OF ARRIVAL	TIME OF ARRIVAL
F.D.C. MIAMI	6/8/95	1200

INMATE'S NAME	REGISTER NUMBER
BAKER, DARRYL	19613-039

MEDICAL CLEARANCE

[1] BP–149(60) REVIEWED? ☐ YES ☑ NO *(Explain):* Records

[2] General Population Housing Approved? ☑ YES ☐ NO *(Specify limitation or need):*

[3] Approved for Temporary Work Assignment? ☐ YES ☑ NO *(Specify limitations or exclusions):*

[4] For Holdovers: OK for Continued Transport? ☑ YES ☐ NO *(Explain):*

[5] Remarks: Clear
NKA

MEDICAL STAFF SIGNATURE	DATE
[signature]	6/8/95
MEDICAL STAFF TITLE	**TIME**
P.A.	1525

ORIGINAL – INMATE CENTRAL FILE
CANARY – FILE

000131

USP LVN

BP–354(60)
APRIL 1990

513-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET** 330 (332-2118)

REQUEST

TO: ophthamalogy (orbital surgeon)

FROM: *(Requesting physician or activity)* ROSS QUINN, M.D. MEDICAL OFFICER Dr Miller

DATE OF REQUEST 5-18-05

REASON FOR REQUEST *(Complaints and findings)* UK

PROVISIONAL DIAGNOSIS

Hx (L) orbit fracture / CT scan result 3-28-05 orbits 3-28-05 head

(L) inferior rectus / diplopia

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
~~ROSS QUINN, M.D. MEDICAL OFFICER~~	ROSS QUINN MF	☐ BEDSIDE ☒ ON CALL	☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY (30-60 days)

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

Approved for ophthalmology consult re necessity of surgical intervention of ? entrapment (L) rectus muscle – 60-90 days

ROSS QUINN, M.D.
MEDICAL OFFICER
JUN 08 2005

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S SSN NUMBER *(SSN or other)*

FSL ELKTON

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

Baker, Darryl 196130397
6-3062

CONSULTATION SHEET
Medical Record 000132

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST
opthamalogist	Dr Keller	1-19-05

REASON FOR REQUEST *(Complaints and findings)*

(VR)

(L) eye 2° HA

PROVISIONAL DIAGNOSIS

Diplopia, Dizziness 2° to Assault. (Send Hx consults)

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
	o	☐ BEDSIDE ☑ ON CALL	☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT
	FSL Feltman	

RELATION TO SPONSOR	SPONSOR'S NAME *(Last, first, middle)*	SPONSOR'S ID NUMBER *(SSN or Other)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)*	REGISTER NO.	WARD NO.
Baker, Daryl 196 13-039		

CONSULTATION SHEET

Medical Record 000133

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST
Radiology - CAT scan	[illegible] MD	09/20/04

REASON FOR REQUEST *(Complaints and findings)*

Inmate ↓ assault → (L) orbital fracture & sx (L) ocular entrapment. Needs CAT scan orbits, ↑ to (L) to F/U fx & prepare for probable surgery

PROVISIONAL DIAGNOSIS

As Above

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[signature]	mm	☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE		DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME *(Last, first, middle)*	SPONSOR'S ID NUMBER *(SSN or Other)*
		FSL ELKTON

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.
Baker, Daryl 1963-039 06/30/62		

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98) 000134
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Optometry / Dr Gabriel | FROM: (Requesting physician or activity) | DATE OF REQUEST: 09/20/04

REASON FOR REQUEST (Complaints and findings)

Inmate S/P (L) orbital fx, has rx eyeglasses (L) eye

Please advise IOP/refraction still OK (Recently arrived from another institution) Thanx!

PROVISIONAL DIAGNOSIS: As Above — L injury occurred 2/04

DOCTOR'S SIGNATURE: ROSS QUINN, M.D. MEDICAL OFFICER | APPROVED: hm | PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☑ YES ☐ NO | PATIENT EXAMINED ☑ YES ☐ NO | TELEMEDICINE ☐ YES ☑ NO

Diplopia on up gaze. Present & ok

V 20/20
PH 20/20

Versions show L eye restricted in up gaze.

11/18/04 - all as before, no apparent change DG

ROSS QUINN, M.D. MEDICAL OFFICER

OCT 25 2004

(Continued on reverse side)

SIGNATURE AND TITLE: D Gabriel OD — DAVID E. GABRIEL, O.D. | DATE: 10/21/04

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other) FSL ELKTON

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade) | REGISTER NO. | WARD NO.

Baker, Darry
19613-039
06/30/62

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98) 000135
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: VR Comm. Ophthalmology

FROM: (Requesting physician or activity) ROSS QUINN M.D. MEDICAL OFFICER

DATE OF REQUEST: SEP 20 2004

REASON FOR REQUEST (Complaints and findings)

Inmate with assault Feb 04 → L orbital fx s entrapment SX L eye. Has ophthalmology consult from another institution dated June 11, 2004 recommending surgery to release L eye (attached)

PROVISIONAL DIAGNOSIS Has pain, diplopia s superior gaze especially. Vision c glasses 20/20 OU. Last date = Dec 2012.

DOCTOR'S SIGNATURE: ROSS QUINN M.D. MEDICAL OFFICER

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☒ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

RECORD REVIEWED ☒ YES ☐ NO

CONSULTATION REPORT

PATIENT EXAMINED ☒ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

Talked with evaluation by Optometrist Mohammed Azam Administrator

(Continue on reverse side)

SIGNATURE AND TITLE

DATE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR

SPONSOR'S NAME (Last, first, middle)

SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no.(SSN or other); Sex; Date of Birth; Rank/Grade)

REGISTER NO.

WARD NO.

Baker, Darryl
19613-039
06/30/62

HEALTH SERVICES
CONSULTATION SHEET
FSL, Elkton, OH
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

000136

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

June 11, 2004

19613-039

Dennis Olson, M.D.
FCI McKean
P.O. Box 5000
Bradford, PA 16701

RE: BAKER, DARRYL

Dear Dr. Olson:

As you know we have been following Mr. Baker's clinical diplopia related to a punch that gave him a blow out fracture. He also has a little bit of anesthesia involving the infraorbital nerve branches. We have given it plenty of time now, almost five months. He still has entrapment; he can not look up with his left eye without experiencing a form of diplopia that gives him extreme imbalance. He does not think that he can function this way.

His acuity is 20/20 in both eyes when he wears his glasses. My advice at this point is to do a repair of blowout fracture, release the entrapment under general anesthesia. I will leave the final decision up to you.

Yours truly,

Robert J Weiss MD

Robert J. Weiss, M.D.

p.s. The patient understand that one of the side effects of doing the operation when he does not have diplopia in down gaze, only up gaze would be that he might develop diplopia in down gaze. There is no way that I can promise him that that couldn't happen.

RJW/lab

H. BEAM, MD
FCI MCKEAN
6/16/04

103 West St. Clair Street
Warren, PA 16365
(814)726-2020
1-877-MD4-EYES
Fax (814)726-1215

27 Porter Avenue
Jamestown, NY 14701
(716)483-2020
1-866-716-EYES
Fax (716)488-9295

2 Main Street
Bradford, PA 16701
(814)362-7477
1-866-814-EYES
Fax (814)362-4975

www.senecaeye.com

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Optometry / Dr Gabriel		09/20/04

REASON FOR REQUEST (Complaints and findings)

Inmate S/P (L) orbital Fx, has Rx entrapment (L) eye
Please advise IOP/refraction still OK (Recently arrived from another institution) Thanx!

PROVISIONAL DIAGNOSIS

As Above

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted] MD	O	☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Chart Copy)

(Continue on reverse side)

SIGNATURE AND TITLE		DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER (SS) or other)
		FSL ELKTON

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)	REGISTER NO.	WARD NO.
Baker, Darry/ 19613-039 06/30/62		

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

000138

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

April 16, 2004

#19613-039

Dr. H. Beam
Health Center
FCI McKean
PO Box 5000
Bradford, PA 16701

Re: Darryl O. Baker
DOB: 6/30/1962
DX: Orbital Floor Fracture w/Entrapment
DATE OF EVAL: 4/15/04

Mr. Baker was seen April 15th. He had been struck in the left eye February 27th with a fist. He was complaining of blurred vision in both eyes. He does note that he gets double vision when he looks up. This is especially noticeable when he is weight lifting and doing, I believe, bent over rows and is looking straight ahead with his head tilted down.

His vision was 20/100 in the right eye and 20/200 on the left. This was easily correctable to 20/20 in either eye with an eyeglass prescription. The eyes were well aligned straight ahead. However, with up gaze the left eye did not elevate or look as far up as the right eye. I did not see any signs that the left eye was protruding further out or recessed into the eye more so than the right. The retina was normal.

The reports of the CT did suggest that there was some scarring of the floor of the orbit with possible adhesions to the inferior rectus muscle. Typically, in ophthalmology even with a fracture of the orbital floor, we like to wait at least two weeks to see that it heals on its own and the muscle entrapment is resolved. He is about six to eight weeks out and complaining of symptoms. Because he is well aligned at near, I think it would be better to take a conservative approach as the scarring is adherent to the muscle. However, it may be worthwhile to get a secondary opinion from an orbital plastic specialist who deals with these on a regular basis.

Thank you for allowing me to participate in Darryl's care. If you do not pursue an orbital evaluation, have him see me again in another three months.

Best regards,

N Stathopoulos, MD

Nicholas A. Stathopoulos, M.D.

NAS/js

Cc Darryl C. Baker

REVIEWED BY: DBeam 4/21/04 H. BEAM, MD. FCI MCKEAN

103 West St. Clair Street
Warren, PA 16365
(814)726-2020
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SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

April 16, 2004

19613-039

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PO Box 5000
Bradford, PA 16701

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N Stathopoulos, MD

Nicholas A. Stathopoulos, M.D.

NAS/js

Cc Darryl C. Baker

REVIEWED BY: 4/21/04 H. BEAM, MD FCI McKEAN

000140

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www.senecaeye.com

9613-039

SENECA EYE SURGEONS, INC.

103 W. ST. CLAIR ST., WARREN, PA 16365 814-726-2020
27 PORTER AVE., JAMESTOWN, NY 14701 716-483-2020
2 MAIN ST., BRADFORD, PA 16701 814-362-7477

PATIENT'S NAME Darryl Baker DATE 4/15/04

ADDRESS

MEDICARE NO. SURGERY DATE

Rx	SPH	CYL	AXIS	PRISM	BASE
OD	-1.75	+1.00	090		
OS	-2.00	+1.25	090		
ADD	+1.25	SPECIAL INSTRUCTIONS			
ADD	+1.25	POLYCARBONATE LENSES RECOMMENDED			

DIAGNOSIS V43.1 / 379.31 OD / OS PROGNOSIS

PRESCRIPTION DURATION 6 MOS

Nicholas A. Stathopoulos MD
PHYSICIAN'S SIGNATURE

PAUL O. KEVERLINE, M.D.
PA LIC. MD-011817-E
NY LIC. 170334-1

ROBERT J. WEISS, M.D.
PA LIC. MD-022030-E
NY LIC. 127219-1

TIMOTHY J. O'BRIEN, M.D.
PA LIC. MD-047466-L
NY LIC. 195904-1

NICHOLAS A. STATHOPOULOS, M.D.
PA LIC. MD-071144-L
NY LIC. 205998-1

CHARLES E. KELLER, O.D.
PA LIC. OE-005123-P

SES017

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

June 11, 2004

19613-039

Dennis Olson, M.D.
FCI McKean
P.O. Box 5000
Bradford, PA 16701

RE: BAKER, DARRYL

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Yours truly,

Robert J Weiss MD

Robert J. Weiss, M.D.

p.s. The patient understand that one of the side effects of doing the operation when he does not have diplopia in down gaze, only up gaze would be that he might develop diplopia in down gaze. There is no way that I can promise him that that couldn't happen.

RJW/lab

H. BEAM, MD
FCI MCKEAN
07/16/04

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13-110 NSN 7540-00-634-4127

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
OPTOMETRIST	Dennis Olson, MD, CD	

REASON FOR REQUEST (Complaints and findings)

EYE EXAM:

SUBJECTIVE: Ruben at for and near consulted Feb 27th

age 41

PROVISIONAL DIAGNOSIS: Retin left eye socket

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION			
D. OLSON, M.D.	O	☐ BEDSIDE	☐ ON CALL	☐ ROUTINE ☐ 72 HOURS	☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity Distance OD 20/200 OS 20/200 TONOMETRY: OD 17 OS 18 uncorrected 0950

Near OD .37m OS .37m

External WNL 72/64 open angles dilate to examine retina

Internal

Refraction OD -1.00 -1.25 x 180 20/20

OS -1.00 -1.25 x 10 20/20

5% x 24 x 6½ Soreness

Diagnosis CMA

Analysis requires eyeglasses

Plan order eyeglasses

0900

on upward gaze left eye stops

trauma to eye socket possible left superior oblique entrapment

(Continue on reverse side)

SIGNATURE AND TITLE	DATE
Christian J. Howard OD	3/31/04

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.
	FCI McKean	14613-039	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade/rank; rate; hospital or medical facility)

Baker, Darryl

REVIEWED BY H. BEAM MD FCI MCKEAN 3/31/04

Referral for MRI of brain and orbit ordered

CONSULTATION SHEET

Medical Record

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9

000143 Refer to ophthalmology

BILL TO:

Baker

OPT A 11

PATIENT NAME: 19613-039 LI-1 | CUST. NUMBER: 110666 | INVOICE NUMBER:

Tray No. 9875 | Date Processed

	Sphere	Cylinder	Axis	Prism	Base Curve
R. EYE	-1.00	-1.25	160		
L. EYE	-1.00	-1.25	10		

	Add	Width	Height		P.D.	N.P.D.
R. EYE			0.0	R. EYE		
L. EYE			0.0	L. EYE		

FRAME DATA

Size	Depth	E.D.	D.B.L.
52.0	46.0	56.0	24.0

Model: 0320272137 TMPL. Length: 52X24

83-84 SMOKE

EDGED UNCUT [A] [ ] LENS ONLY [ ] ENCLOSED [ ] TO COME [ ] SUPPLIED [ ]

LENS DATA

	Type	Material
R:	SV CR-39 SRC1	SOLA 72
L:	SV CR-39 SRC1	SOLA 72

FDA CODE SEC. 3, 84, 21 CFR

THESE LENSES ARE IMPACT RESISTANT AND IN COMPLIANCE WITH FDA TESTING PRESCRIBED IN SEC. 3, 84, 21 CFR IMPACT RESISTANT LENSES ARE NOT UNBREAKABLE OR SHATTERPROOF.

NOTE FOLLOWING EXCEPTIONS

(1) PLASTIC: Mfr. certifies lenses ground to specifications are impact resistant within FDA code.
(2) UNCUT GLASS lenses have not been treated or tested and must be made impact resistant before dispensing.
(3) RAISED LEDGE multifocals have been made impact resistant, but are exempted from drop ball testing.

COMMENTS:

J-10219303 LI-1 T-9875

OPT A 20

RP

CHARGES

DESCRIPTION	PRICE
RIMS	
LENS	
83-84	
SHIELD	
Sub Total	
Freight	
Total Due	

Darryl Baker

FROM: 110666 8418 POSTMASTER
IF THIS PACKAGE IS NOT DELIVERED IN FIVE DAYS, PLEASE RETURN TO SENDER

SHIP TO:
FCI MCKEAN HEA
RT 59 BIG SHAN
LEWIS RUN, PA 167

Eyeglass Prescription

TRAY NO. | ARRIVAL DATE | PRESCRIPTION NO.

INSTITUTION:

CITY

STATE ZIP

LENSES

EXTRA

FRAME OR MTG

MISC

BAKER, Darryl
19613-039
FCI - McKean

		SPHERE	CYLINDER	AXIS	PRISM	DIRECTION	IN DEC OUT
DISTANCE	R	-1.00	-1.25	180			
	L	-1.00	-1.25	10			
ADD	R						
	L						

SEGMENT INSTRUCTIONS

HEIGHT R	HEIGHT L	WIDTH	INSET R	INSET L	PUPILLARY WIDTH DIST.	PUPILLARY WIDTH NEAR
					72	X

SEG. STYLE

ORTH. F TILLER D	EXECUTIVE TYPE	KRYPTOK	PANOPTIK	CURVED TOP	TRIFOCAL AND TYPE	STRAIGHT TOP	OTHER.
22		22	22-24	22-25		22 28 45 25 35	

FRAME OR SHAPE

	EYE SIZE	BRIDGE SIZE	TEMPLE LENGTH AND STYLE
29 Smoke	52	24	6¼

SPECIAL INSTRUCTIONS
( ) LENS ONLY
( ) FRAMES ONLY
plastic

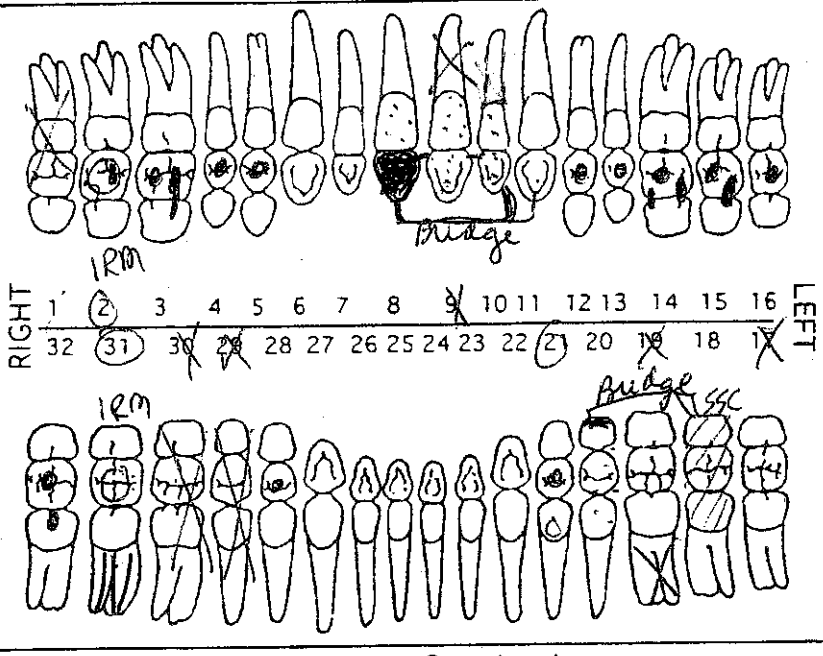
Mail to:
Federal Prison Industries
Box 100
Butner, N.C. 27509

Christian J. Howard 3/31/04
SIGNATURE DATE
USP LVN

BP-357(60)
MAY 1984

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Examination: ☐ Screening ☐ Comprehensive ☐ Periodic



Occlusion Cl I

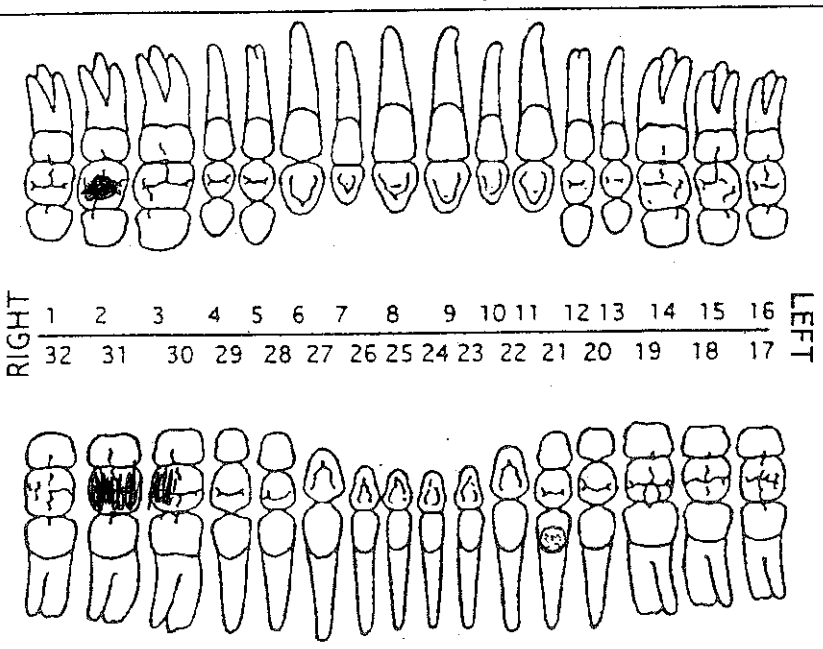
Oral Hygiene Good (Fair) Poor

CPITN 2 | 2 | 3
2 | 2 | 2

Head & Neck/Soft Tissue
WNL

Additional Findings
D: 3
M: 5
F: 14

Treatment Completed



Recommended Treatment Plan

☐ Radiographs
~~28W Pan X~~

☐ Dental Prophylaxis 1-6-05
☐ Oral Hygiene Instruction

☐ Periodontal Evaluation 0 (I) II III

☐ Oral Surgical Procedures
0

☐ Endodontic
0

☐ Restorative
~~# 20~~ ~~# 31 CPA~~ PTC
~~# 21B~~
~~HH~~

☐ Prosthodontic Evaluation
0

Patient Name Number Sex: (M) F Age:

Baker, Darryl 19613-039

Dentist Signature Date

Charles Houck, DDS 11-16-04

000146

FSL ELKTON

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
8-17-04		S: Sore tooth - points to #31
0800		O: Endo complete - defect temp - lost space to max.
		A: Dfy. temp #31 - possible endo failure
		P: No LA - re-temp #31 mo - caution pt to seek follow-up if persist. TA develops
		Charles Houck, DDS
11-16-04		Comp. exam. Head & neck exam, soft tissue
1300		CPITN, OMF, 2BW, Pan X; Medical history reviewed & updated. NV→ hygiene
		Charles Houck, DDS
1-6-05		Med Hx needs done at next appt. - Perio
1000		Mod Sub/interprox calc & Mod to heavy bleeding Hand scaled throughout polished & flossed OH given verbal & printed NV: Ops/Salisbury JACKIE SALISBURY RDH
2-2-05		LA 36mg Lido, 0.018 epi
1200		Excavate 216 - A3.5 composite
		NV→ 2° Charles Houck, DDS
2-18-05		LA 36mg Lido, 0.018 epi
1200		Excavate dfy SA #2° - optibond/SA
		Charles Houck, DDS
3-16-05		Build-up #31 as much as occlusal constraint
1000		allows - optibond/SA #31 MOD
		PTC
		Charles Houck, DDS